The Evidence for Community Paramedicine in Rural Communities

Karen Pearson
Flex Monitoring Team and
Maine Rural Health Research Center

National Rural Health Association
Annual Meeting
Louisville, KY

May 9, 2013

A Performance Monitoring Resource for
Critical Access Hospitals, States, and Communities

Flex Monitoring Team | University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

Acknowledgements

- John Gale and George Shaler, University of Southern Maine
- Federal Office of Rural Health Policy
- National Association of State EMS Officials
- National Highway Traffic Safety Administration
- State Offices of Rural Health/Flex Program staff
- State EMS directors and staff
- EMS providers

Overview of the Flex Community Paramedicine Project

Purpose: To examine

- Evidence base for the use of community paramedics,
- Role for these personnel in rural healthcare delivery systems,
- Challenges states have faced in implementing programs,
- Role of state Flex Programs in supporting community paramedicine programs.

Overview (cont'd)

Methods:

- Literature Review
- Review of State Flex Grant Applications
- In-depth interviews with state and local stakeholders, including:
  - State Office of Rural Health/Flex Coordinators
  - State EMS Directors
  - EMS providers
  - Hospital administrators

What is Community Paramedicine?

Brief history:

- Red River project (New Mexico), 1992
- EMS Agenda for the Future, 1996
- "Solving the Paramedic Paradox," 2001
- Rural & Frontier EMS Agenda for the Future, 2004
- Joint Committee on Rural Emergency Care (JCREC), 2010
- HRSA Community Paramedicine Evaluation Tool, 2012

Defining Community Paramedicine

No universal definition, but common themes:

- An emerging field in health care where EMTs and Paramedics operate **in expanded roles** in an effort to connect underutilized resources to underserved populations. (*HRSA, Community Paramedicine Evaluation Tool, 2012*).
- A model of care whereby paramedics apply their training and skills in "non-traditional" community-based environments (**outside the usual emergency response/transport model**). The community paramedic may practice within an "expanded scope" (applying specialized skills/protocols beyond that which he/she was originally trained for), or "**expanded role**" (working in non-traditional roles using existing skills). (*International Roundtable on Community Paramedicine*)
- An organized system of services, **based on local need**, which are provided by EMTs and Paramedics integrated into the local or regional health care system and overseen by emergency and primary care physicians. (*Rural & Frontier EMS Agenda for the Future, 2004*)

What is a Community Paramedic?

Community Paramedic*: *A state licensed EMS professional

- Completed a formal internationally standardized Community Paramedic educational program through an accredited college or university,
- Demonstrated competence in the provision of health education, monitoring and services **beyond the roles of traditional emergency care and transport**, and in conjunction with medical direction.
- The specific roles and services are **determined by community health needs and in collaboration** with public health and medical direction.

(*HRSA, Community Paramedicine Evaluation Tool, Appendix B, 2012*)

Differing Rural/Urban Goals to Community Paramedicine

Rural addresses

- Primary care shortages
- Geographic distances to nearest hospital
- Utilization of paramedics during "down time"
- Career path opportunities

Urban addresses

- High volume of 911 calls
- Wait time in the ED

Both look to keep patients in their homes, reduce hospital readmissions and frequent ambulance transports

Preliminary Findings from State Interviews

We contacted15 states engaged in Community Paramedicine (CP) development:

State EMS Agencies: GA, IA, ME, NE

SORH/Flex: AZ, CO, GA, IA, ME, MN, NH, ND, PA, SC, WI

Local EMS agencies: CO, WI

Local organizations: AL (urban model), NY (Assoc. Prof. Emergency Medicine, University of Rochester, School of Medicine), WA (Prosser Memorial Hospital-CMS Innovation Award grantee),

Nova Scotia Emergency Health Services Director of Provincial Programs

Findings from State Interviews, (cont'd)

- Most CP programs are initiated at the "grassroots" level: Local ambulance companies seek out hospitals or other health care agencies with which to collaborate/partner
- Stakeholder groups are essential to successful development and buy-in of CP programs
- Community needs assessments are critical to developing CP goals and services
- Training varies, from established national curriculum to in-house trainings with partner agencies
- Reimbursement is a significant challenge

Community Paramedic Services

Dependent on the needs of the community, but typically includes:

- **Assessment**
- Blood draws/lab work
- **Medication compliance**
- **Medication Reconciliation**
- **Post-discharge follow-up** within 48-72 hours as directed by hospital, PCP, or medical director
- Care coordination
- **Patient education**
- Chronic **disease management** (CHF, AMI, Diabetes)
- **Home safety assessment**: e.g. falls prevention
- **Immunizations and flu shots**
- Post-surgical wound care (not all CPs have this in their scope of practice)
- **Referrals** (medical or social services)

Funding Community Paramedicine Programs

- Reimbusement issues are the most challenging for the "non-transport" services provided by CPs
- Funding for the CPs most often is provided by the ambulance company
- Some hospitals provide funding for CPs
- Grants: CMS Innovation Grant (WA-rural hospital model, NV-urban model)
- Commercial insurer: PA (urban model)
- State Office for Aging: NY

Findings from State Interviews: Legislative/Regulatory changes

Most states trying to work within existing EMS scope of practice (not requiring regulatory change)

- **CO:** initially licensed as Home Health Provider, currently working on new regulatory framework for CPs
- **ME:** legislative change to authorize CP pilot projects
- **MN:** legislative change certifying CP as provider type eligible for Medicaid reimbursement
- **NE:** legislative change to remove the word "emergency" from the scope of practice
- **WI:** legislative change to allow pilot project for CP to work outside scope of practice

Role of the State Flex Program

- **2010-2011**: Five states Flex programs undertook Community Paramedicine activities
- **2012:** Nine states included Community Paramedicine initiatives in their State Flex Grant applications, with six states providing funding for CP activities
- State Flex offices/staff provide facilitation of stakeholder meetings and dissemination of CP opportunities.
- Partnership of State Offices of Rural Health and State EMS agencies

Concluding Thoughts

- No "cookie cutter" approach to CP programs:
  - Based on community needs
  - Role of CP similar, but services may be different
- Partnerships and collaboration at local and state levels are essential
- Funding mechanisms and reimbursement for services needs careful consideration
- Data collection is key
- Evaluation

Resources

- CommunityParamedic.org
- International Roundtable on Community Paramedicine
- *Community Paramedicine Evaluation Tool* (HRSA)
- *Community Paramedic Handbook* (Western Eagle County Health Services District & North Central EMS Institute)
- *National Consensus Conference on Community Paramedicine* (Patterson and Skillman, 2012)
- National Association of State EMS Officials (NASEMSO)
- National Highway Traffic Safety Administration (NHTSA)

Contact Information

Karen B. Pearson, MLIS, MA
Muskie School of Public Service
University of Southern Maine
PO Box 9300
Portland, ME 04104-9300

207.780.4553
karenp@usm.maine.edu